STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	06/27/2017

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NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from 6/19/17 through 6/27/17. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 61. The Stage 2 survey sample size was 21. Abbreviations/definitions used in this report are as follows: MD - Medical Doctor; Psychiatrist - physician for treatment of mental disorders; NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; ADL - activities of daily living. such as bathing and dressing; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (for example Risperdal, Seroquel); BM - bowel movement; cognitive/cognition - mental action of acquiring knowledge and understanding through thought, experience and the senses; Continent/cont/continence - voluntary control of bladder and/or bowel function; d/cd-discontinued; Cross Contamination - the spread of germs and bacteria; Dementia-group of thinking and social symptoms that interfere with daily functioning; etc-and so forth;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/13/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 f/u-follow up; Incontinent/incont/incontinence - loss of bowel and/or bladder control; MAR-Medication Administration Record; mg - milligram - measurement of weight; MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; Non-Pharmacological - with out use of medication; Occasionally incontinent - less than seven (7) episodes of incontinence during the seven (7) day review period; Overactive Bladder (OAB) - problem with the bladder storage function that causes a sudden urge to urinate and difficult to control; urinate frequently; PO- By Mouth; POS-physician order sheet; PRN - as needed; Pt - patient; pre-before; post-after; Prognosis - a prediction of the probable course and outcome of a disease; q- every; TID- three times a day; TB Testing - tuberculosis testing; UTI - urinary tract infection; Vitamin D-nutritional supplement used to aid in bone development; Urine Analysis (UA) -test used to detect and assess a disease or illness; Culture & Sensitivity (C&S) -test to see what bacteria is causing the infection and which antibiotic will kill it.	F 000		
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		8/27/17

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F 253	Continued From page 2 (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to ensure that carpeting in resident areas were maintained in good repair. Findings include: During the observation periods from 6/19/17 through 6/23/17, between 10 AM and 4 PM and 6/26/17 to 6/27/17, between 10 AM and 4 PM, carpeted hallways from all three floors housing residents were found to have areas that were worn out, revealing frayed surfaces. Frayed surfaces were more noticeable on the second and third floors of the building, with damage to the carpet being observed at the entrance to the shower room on the second floor; in the hallway, and outside resident rooms 221 and 214. Carpeting was in disrepair in the activity room on the third floor and throughout the third floor hallway. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/27/17 at 2:15 PM.	F 253	1. The carpet on all three floors and near rooms 221 and 214 were inspected and all frayed edges were secured. The activity room and the entrance to the shower room were repaired until the new floor surface arrives. 2. All residents will continue to receive supervision until the carpet is replaced. 3. Estimates will be received for new flooring. Maintenance will continue to monitor flooring and nursing will report to maintenance any noted problems. See attachment #1 4. Environmental Services director will audit the flooring to ensure no frayed areas or tripping hazards weekly x4 then monthly x2 and then quarterly. This audit will be reported at the QA meeting. See attachment #2 The new flooring will be replaced by 8/27/2017.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		8/27/17

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F 309	Continued From page 3 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that the facility failed to use the same pain scale consistently for pre (before) and post (after) pain medication administration for two (R2 and R68) out of 21 residents. Findings include: Pain management standards were approved by	F 309	1. R2 and R68□s pain scale was revised to ensure that staff will be utilizing the pain scale pre and post pain medication administration. 2. All residents□ pain scale was updated to ensure that staff utilize the pain scale pre and post pain medication	

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F 309	Continued From page 4 the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility policy entitled "Pain Management" last updated 12/8/16 included the following: - Routine and PRN (as needed) medication prescribed for the management of pain will be monitored for effectiveness and for the need of intermittent (not constant) adjustment of dose, frequency and type of medication utilizing a pain scale of 1 to 10. 1. Review of R2's clinical record revealed: 2/8/17 - R2's care plan for pain included the following interventions: monitor/record pain characteristics each shift and PRN; quality, severity using 1-10 scale; location, duration onset aggravating, alleviating factors. April 2017 - June 2017: Review of MARs, pain assessment sheet and nursing notes found the pain assesment using the 0-10 pain scale was not completed before and/or after PRN administrations of pain medication on 91 out of 91 occasions when PRN pain medications were administered. 6/14/17 - A consult with a physician specializing in pain management documented in reference to R2's pain "standing, and bending worsens (the pain), warmth and medications help, with 4/10	F 309	administration. Attachment #3 3. All nursing staff will be in-serviced to the change in policy in regards to proper pain scale utilization by 7/27/17. Attachment #4 and #5. 4. An audit will be developed and completed by the staff educator/designee weekly x4, monthly x2 and then quarterly to ensure that staff are using the pain scales appropriately. Attachment #6	

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F 309	Continued From page 5 pain at baseline and 10/10 at worse." During an interview on 6/20/17 at 10:38 AM R2 responded "Yes" when asked "Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief?" During an interview on 6/23/2017 at 2:23 PM with E6 (LPN) it was reported that after the administration of PRN pain medication residents are assessed for pain without the use of a numeric scale "we ask whether pain was relieved and sometime if they are sleeping we don't ask because you know its relieved." These findings were reviewed with E1 (NHA) and E2 at the exit conference on on 6/27//17 at 2:15 PM. 2. Review of R68's clinical record revealed: 3/9/17 - R68's care plan for pain included the following interventions: monitor/record pain characteristics each shift and PRN; quality, severity using 1-10 scale; location, duration onset aggravating, alleviating factors. April 2017 - June 2017- Review of MARs, pain assessment sheet and nursing notes found the pain assesment using the 0-10 pain scale was not completed before and/or after PRN administrations of pain medication on 227 occasions out of 227 occasions when PRN pain medications were administered. During an interview on 6/20/17 at 11:42 AM with R68 it was revealed that he was having	F 309		

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F 309	Continued From page 6 discomfort such as pain, heaviness, burning, or hurting with no relief and that he was "not able to do what he used to do, and then R68 asked for pain medication and said he had pain scored 10/10 and was in a lot of pain." R68 was medicated for pain during the interview. During an interview on 6/23/17 at 1:43 PM with E17 (RN) it was reported that pain assessments post administration of PRN pain medication are documented "in the MAR, we document effective or not and we write a note." E17 further explained when asked "How do you know the PRN is effective if you are not using the numeric pain scale?" E17 stated "we see their facial expression?" During an interview on 6/26/17 at 2:45 PM with E2 (DON) it was confirmed that staff should be using a consistent pain scale for both pre and post assessment of pain after administration of a PRN pain medication. These findings were reviewed with E1 (NHA) and E2 at the exit conference on on 6/27//17 at 2:15 PM.	F 309		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		8/27/17

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F 329	Continued From page 7 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R39) out of 21 sampled residents the facility failed to ensure non-pharmacological interventions were attempted before starting an antipsychotic medication, and that antipsychotic medication had adequate indication for use and adequate monitoring. Findings include:	F 329	1. R39□s Seroquel has been discontinued as of 7/11/17. R39 continues to have behavior monitoring completed. 2. All residents will be reviewed to ensure that they have appropriate behavior monitoring tools in place and that non-pharmacological interventions are utilized and the proper indication for use is	

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F 329	Continued From page 8 Facility policy for Psychotropic Medication Use (undated) included under procedure: All orders for psychotropic medications are for the purpose of treating medical symptoms after alternative measures have failed: initiate a behavior monitoring form and document daily frequency of behavior, interventions, effect of interventions and side effects. Review of R39's clinical record revealed: 4/18/17 MD progress note - ...increased confusion, appears currently at baseline encourage po fluids; dementia may have periods of confusion decline to be expected. 4/19/17 5:27 PM Progress note - Aides reported that as dinner was being served, this patient picked her drink up and threw it at another patient [SSR#1] sitting at the same table. 4/19/17 8:46 PM Progress note - Update aides reported earlier in shift patient had taken a babydoll from the same patient [SSR#1] she later threw her drink on. 4/20/17 10:38 PM Progress note - Resident refused medication for no bowel movement in 3 days (constipation). 4/21/17 2:01 PM Progress note - Resident received medications for no bowel movement in 3 days. 4/21/17 9:22 PM Progress note - PRN suppository given (for constipation)...Patient continued with increased behaviors taking another patient's [SSR1] doll from her and pacing	F 329	documented. The policy for Psychotropic medication use has been updated. Attachment #7 3. All nursing staff will be in-serviced on the updated policy and the monitoring of psych drug by 7/27/17. 4. An audit will be completed by the staff educator/designee to ensure compliance with the behavior monitoring tool and all new orders of psycotropic medications weekly x4 , monthly x2 and then quarterly. This will be reviewed at the quarterly QA meeting. Attachment #8	

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F 329	Continued From page 9 before and after dinner... 4/21/17 MD progress note- Asked by nursing staff to see patient (pt) secondary to increased aggression / agitation. Pt was involved in altercation with another resident... will fu (follow-up) with UA C&S most likely secondary to dementia... There was no evidence that monitoring of specific behaviors was initiated or what non-pharmacological approaches were used. 4/23/17 8:17 PM Progress note - Resident was up and walking without her walker multiple times and trying to pick up items on dining room tables... 4/25/17 Psychiatrist consult - Per report, the patient has been very aggressive with support staff, irritable. Per report, patient has been throwing things at support staff and at times very hard to redirect...Plan we will start patient on Seroquel [anti-psychotic] 25 mg three times a day. 4/26/17 MD order from psychiatrist - Seroquel 25 mg TID for dementia with behaviors. 4/26/17 MD order - For antibiotic for 7 days to treat a positive urinary tract infection. There was no identification of exactly what behaviors the Seroquel was being started for and no evidence that specific behaviors were being monitored. It was unclear what non-pharmacological interventions were put in place prior to starting medication. It was also unclear if the psychiatrist was aware of the	F 329		

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F 329	Continued From page 10 urinary tract infection and constipation when initiating treatment. 4/27/17 - Asked by nursing staff to see patient. With UTI...increased confusion/falls agitation in recent past...UTI on treatment...behavior disorder pt started on Seroquel by psychiatry today, dementia general decline present moderate to severe dementia. 5/1/17 2:03 PM Progress note - ...Becomes argumentative and resist staff when try to redirect for safety. Noted resident put on a pair of gloves and refused to remove them... 5/2/17 9:24 AM Progress note - Late entry for 4/25/17 seen by psych due to aggressive behaviors with staff and other residents. Plan will start Seroquel three times a day, notify provider for worsening symptoms or behaviors. 5/2/17 - Care plan for use of psychotropic medications related to behavior management with approaches that included; monitor/record occurrence of target behaviors symptoms (violence/aggression towards staff/others etc. and document per facility protocol. 5/18/17 MD Progress Note - Asked by nursing staff to see patient secondary to increased lethargy patient does not want to walk able to walk. Patient started on Seroquel recently...will decrease to twice daily. June 2017 - Behavior monitoring sheets for resists care and combative. 6/22/17 11:08 AM - Interview with E4 (RN) about behavior monitoring and psychiatry consult	F 329		

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F 329	Continued From page 11 revealed R39 was agitated when in another resident's room and messed up clothing, the closet, bed and was yelling. She was much better after she finished her antibiotic for a urinary tract infection. The only behavior monitoring form found was for June of 2017. At 2:40 PM E4 stated that monitoring of specific behaviors could not be found for April or May 2017, E4 added that residents on Risperidol and Seroquel (antipsychotic medications) should have behavior sheets initiated. 6/23/17 11:23 AM - Interview with E20 (LPN) and E4 revealed that R39 started having behaviors 1 to 2 weeks before the psychiatrist was called including going in other residents' rooms and being combative with aide. It was revealed that the behaviors got better when the antibiotic was finished. The primary doctor decreased the Seroquel to twice a day. 6/26/17 9:54 AM - Interview with E2 (DON) revealed R39 had an incident of her throwing juice at another resident, running up and down hall, pushing tables we were scared she was going to hurt someone, we called psychiatrist and he started Seroquel, we did get a urine sample (for testing), she did have some behaviors that decreased when R39 finished the antibiotics. The lack of behavior monitoring and non-pharmacological intervention was confirmed with E2. The above findings were reviewed with E1 (NHA) and E2 during the exit conference on 6/27/17 at 2:15 PM.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		8/27/17

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F 371	Continued From page 12 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store/serve food under sanitary conditions: Findings include: 1. According to the professional standards for food safety, employees must clean their hands immediately before donning (putting on) gloves and after engaging in activities that contaminate the hands,single use gloves must be used for only one task. During a dining observation on the first floor on	F 371	1. The kitchen ceiling above the pots and pans was cleaned on 6/28/17. The two CNAS□s were educated on 6/28/17 in regard to safe food handling. The open container of milk and the expired pumpkin was discarded immediately. Attachment #9 and #10 2. All other kitchen ceiling areas were inspected for cleanliness and cleaned. All food present in the building was checked for proper storage and expiration dates.	

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F 371	Continued From page 13 6/19/17 at 12:24 PM E5 (CNA) touched the doorway frame with her right gloved hand then at 12:27 PM using the same gloved hand touched a resident's roll [SSR#2]. 2. During lunch on 6/22/17 at 12:47 PM, R5 was observed trying to eat spaghetti with an adaptive spoon. Observing food spilling back onto R5's plate, E15 (CNA) came over to assist R5 and began to feed the resident. Per R5's request, E15 then took the biscuit from the plate with her bare hand and proceeded to put it in R5's mouth. 3. Kitchen inspection on 6/26/17 at 10:30 AM revealed 15 pots and pans, uncovered, hanging in storage beneath a dusty ceiling. The walk-in refrigerator had one opened container of milk that was unlabeled with no date opened or use-by date, and a container of expired pumpkin. The above findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/27/17 at 2:15 PM.	F 371	Discarded as necessary. 3.All dietary staff will be in-serviced by the Dietary Manager by 7/27/17 in regards to proper labeling, procedure for expired foods and the cleanliness of the kitchen. All nursing staff will be in-serviced by 7/27/17 by the staff educator/designee in regards to proper food handling. Attachment #11 4. An audit will be developed and completed by the Dietary Manager to ensure proper labeling and the monitoring of expired foods and the cleanliness of the kitchen. The staff educator will complete an audit for safe handling of foods. These audits will be completed weekly x4, monthly x2 and then quarterly. All audits will be reported at the facility QA meeting. Attachment #12	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility;	F 425		8/27/17

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	08A020	A. BUILDING _____ B. WING _____	06/27/2017

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F 425	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that the facility failed to ensure that biologicals and medications were not expired for 1 out of 4 medication carts observed. R73 was administered a prescribed medication that had expired 4 months prior. Findings include: 6/20/17 at 1:45 PM, the surveyor observed on the second floor that the medication cart #2 contained a bottle of Vitamin D3 2000 units for R73 that had an expiration date of February/2017. Clinical record review for R73 revealed the following: Vitamin D3 2000 units was prescribed by the physician on June 6, 2017 for R73's diagnosis of Vitamin D deficiency. R73's June 2017 MAR (Medication Administration Record) revealed that R73 was administered the expired medication daily from 6/7/17 through 6/20/17, for a total of 13 days. In addition, according to E16 (LPN), the bottle of the expired Vitamin D3 2000 units did not come from the pharmacy but was given to the facility by a family member for R73 to use. This finding was reviewed and confirmed with E2 (DON) on 6/20/17 at 2:45 PM. The above finding was discussed at the exit conference with E1 (NHA) and E2 on 6/27/17 at 2:15 PM.	F 425	1. R73□s Vitamin D3 was disposed of immediately. 2. All residents medications that were brought into the facility by family were reviewed to ensure that there are no expired medications. 3. A new policy has been developed to ensure that medications brought in by family members are reviewed for accurate med, right dose, and the expiration date. The nursing staff will be in-serviced in regards to this policy by 7/27/17. Attachment #13 4. An audit will be developed and completed by the staff educator/designee to ensure that there are no expired medications on the med cart. This will be completed weekly x4, monthly x2 and then quarterly and will be reviewed at the facility QA meeting. Attachment #14	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		8/27/17

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F 441	Continued From page 15 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 16 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observations, interviews, review of clinical records, and a review of other facility documents it was determined that the facility failed to ensure that 1 (R68) out of 6 residents and 2 (E18 and E19) out of 15 staff reviewed received a 2 step TB test as required. In addition, facility staff failed to process and store linens in a clean and safe manner to prevent cross contamination and the spread of infection. Findings include: The facility immunization policy last updated	F 441	PPD 1. R68 was given a two-step PPD initiated on 6/26/17. The two employees were given PPD□s initiated on 6/24, and 6/26/17. Attachment #15,16 and 17 2. All residents and staff□s PPD□s were reviewed for accuracy. 3. A new policy was developed for both staff and residents to ensure that PPD□s are given as required. Attachment #18	

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F 441	Continued From page 17 12/8/16 included the following: - All residents will receive a two-step PPD (TB) test on admission and an annual PPD thereafter for negative reactors. - Documentation of the vaccination will be recorded on the MAR and on the immunization form which will include date, site, and nurses' initials. 1. Review of R68's clinical record revealed: February 2017 MAR - Documented that R68 refused the TB skin tests on February 15 and 16. February 2017 - Review of physicians' orders, physician notes and progress notes found no evidence that the physician was notified of the refusal, that documentation of TB test results from the prior facility or that a chest x-ray was completed / obtained. 2. Using information human resources recorded on a personnel audit spreadsheet provided by the surveyor, there was no evidence that a second TB test was performed for the following: -E18 hire date 1/18/17 -E19 hire date 3/2/17 During an interview on 6/27/2017 at 11:30 AM with the surveyor, E2 (DON) confirmed that second step TB tests were not performed and that the facility was initiating the two step TB test process over again for R68, E18 and E19. 3. Surveyor observations and staff interviews: -6/26/17 at 10:07 AM - Floor 3 - there were two carts containing clean linens with multiple stains on the mesh coverings and/or ripped areas and	F 441	and 19 4. An audit will be completed by the staff educator/designee to ensure compliance with proper PPD administration weekly x4, monthly x2and then quarterly. This audit will be reviewed at the QA meeting. Attachment #20 and 21 Linen Carts 1. New mesh linen cart covers were ordered on 7/3/17. Notices were posted on the laundry room doors indicating that the doors, including the accordion door need to remain closed at all times. 2. All other linen cart covers were inspected and replaced as necessary. 3. All linens will be covered and maintained in a clean and safe manner to prevent the spread of infection. Laundry and nursing staff will be in-serviced on the need to maintain the laundry room doors closed and to keep the linens covered to prevent the spread of infection. Attachment #22 4. An audit will be developed and completed by the Maintenance Supervisor weekly x4, monthly x2 and then quarterly to ensure the storage of linens and to prevent cross contamination and the spread of infection in the laundry area. These audits will be reviewed at the QA meeting. Attachment #23	

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F 441	Continued From page 18 clean bedding was observed sticking out of the backside of one of the carts. -6/26/17 at 10:12 AM - Floor 3 - dirty laundry room front door open to a foyer area right next to the clean laundry room which had its front door open to the same foyer area - a small accordion door between the dirty and clean rooms was also partially open. -6/26/17 between 10:26 AM and 10:40 AM - Floor 2 - the mesh covering on a clean linen cart did not fully cover the linens on one side, there was a large gap and linens were also observed sticking out of the back of the cart exposed and not fully covered; the mesh had ripped areas. The mesh covering on another cart was observed with stained areas; linens were sticking out of the back of the cart, and were not fully covered. -6/26/17 between 11:33 AM and 11:55 PM - Floor 3 - Both the dirty and clean laundry front doors were open to the small foyer. The rooms are right next to each other. In addition, the small accordion door between the two rooms was observed partially open. -6/26/17 at 12:25 PM - during an interview with the surveyor, E13 (Laundry staff) stated that the accordion door is generally closed and must have been opened by the night shift. E13 further stated that the dirty and clean laundry room front doors are always kept opened. He/she has been working in the laundry for a little over a year now. -6/26/17 at 12:28 PM - during an interview with the surveyor, E7 (Environmental Services Director) stated that generally the dirty and clean laundry room front doors are kept open during the	F 441		

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F 441	Continued From page 19 day and closed on the night shift as a safety measure. The surveyor did inform E7 that to prevent cross contamination and prevent the spread of infection; the accordion door, and the front doors need to be kept closed. -6/27/17 at 8:52 AM - the surveyor accompanied by E7 observed the door to the dirty laundry room open and that E14 (Housekeeping/Laundry staff) was putting dirty clothes into a washing machine. E7 informed E14 that he/she needed to keep the door closed to the dirty laundry room. The above findings were discussed during the exit conference with E1 (NHA) and E2 (DON) on 6/27/17 at 2:15 PM.	F 441		
F 464 SS=E	483.90(h)(1)-(4) REQUIREMENTS FOR DINING & ACTIVITY ROOMS (h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- (1) Be well lighted; (2) Be well ventilated; (3) Be adequately furnished; and (4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have	F 464	1. All 5 residents are eating in the dining room after the dining room has been	8/27/17

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F 464	Continued From page 20 sufficient space to conduct dining on 1 (unit 2) out of 3 resident units. Findings include: 6/19/17 - Observation at 12:05 PM of the seating plan posted for the 2nd floor dining room noted 6 residents were to be seated at portable over the bed tables (OBT) in the hall in front of resident rooms across the hall from the dining area. 6/19/17 12:05 PM - Random observation of the lunch meal revealed 5 residents [SSR#3, SSR#4, SSR#5, SSR#6, SSR#7] eating lunch on over the bed tables. 6/27/17 9:49 AM - Interview with E4 (RN) revealed that because the dining room tables are full they use the OBT tables for the other residents. 6/27/17 10:20 AM - Interview with E2 (DON) revealed that the residents eat on the OBT because they just don't have room to all eat in the dining area at tables. The facility has thought about changing times and doing two seatings but all the residents want to eat together. E2 added that they have been thinking about what staff could do for the residents' dignity but have not figured it out yet. The above findings were reviewed with E1 (NHA) and E2 during the exit conference on 6/27/17 at 2:15 PM.	F 464	rearranged for accommodation. 2. All residents will continue to eat in the dining room. Ongoing assessments will be completed to ensure the appropriate accommodations along with the residents □preferences. 3. A new seating chart was developed to incorporate all residents. Nursing staff will be in-serviced on the need to have all residents in the dining room for meals by 7/27/17Attachment #24 4. An audit will be developed and completed by the staff educator/designee to ensure compliance with dining room seating. This will be completed weekly x4, monthly x2 and then quarterly. This will be reviewed at the QA meeting. Attachment #25	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

FACILITY: Newark Manor

DATE SURVEY COMPLETED: June 27, 2017

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from 6/19/17 through 6/27/17. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 61. The Stage 2 survey sample size was 21.	Please refer to CMS 2567 for POC	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on June 27, 2017: F253, F309, F329, F371, F425, F441, and F464.		

Provider's Signature _____ Title Administrator Date 7-14-17